# *Investigation of 7ID-C Laser Incident (8/9/08)*

- General user suspected that he viewed diffused laser light
  - Investigation of administrative practices concluded and report issued
- No evidence for exposure, but could have happened
  - Vertical beams unshielded during alignment
  - Protective eyewear improperly worn
- Experiment received proper approvals
- Approval and review process could be improved, for example:
  - Improved training for LCAS, visiting researchers using Class III/IV lasers?
  - Multiple Laser Operating Permits for single source/ multiple beam path setups?
- Other factors
  - Unclear responsibilities for LCAS
  - PI had not considered the use of standardized shielded optical path segments
  - Inadequate management attention to staffing and training for high hazard experiments
- Causal analysis, corrective actions being developed, lab-wide response also sought